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Contents

ISSUE THEME: *The Other Organizations of American Medicine*

HDMS Administration 1976-1977 4
Your President's Page - A Full Time Leader?
by Bruce B. Stoler, M.D. 5
Theme Article: Some Aspects of Medical Practice Today and Possible Future Trends
by Carl W. Janovsky, M.D. 6
A Summary of Comments made to the Department of Public Welfare by Walter F. Tauber, M.D. 8
Featured Article: What Should We Render To Caesar?
by H. Thomas Ballantine, Jr., M.D. 10
Theme Article: Western Massachusetts PSRO Inc.
by Norman B. Pike, M.D. 13
Theme Article: Health Care Foundation of Western Massachusetts, Inc. by Robert N. LaMarche, M.D. 14
Coming 27th of March – New Black Eagle Jazz Band 16
The Page of the Auxiliary to the HDMS
by Carrol Jean Yorzyk, President 17
Res Ipsa Loquitur: Observations in the Radiation Suite
by Charles W. Barnes, Ph.D. 18
Series Article: Views of a Hospital Administrator,
Noble Hospital – Mr. George B. Brooks 20
Presidential Comments – Bruce B. Stoler, M.D. 22
Food for Medical Thought:
Second Area Doctor Heads South Of the Border
by Hank Reinink, The Napanee Beaver 23
Poet's Corner: The Doctor is the Patient or My Couplet Runneth Over by Howard N. Simpson, M.D. 25
A Doctor's Prayer by John J. Alifano, Sr., M.D. 26
Editorial Comment: "Roots" and the Concepts of Freedom—Personal and Dependent
The Editor-in-chief 28
List of Advertisers – Please let them know you saw their advertisement 30

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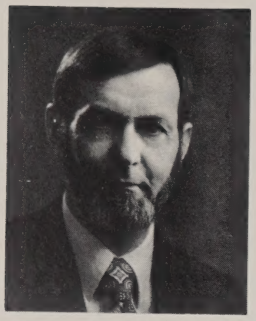

Bruce B. Stoler, M.D.

Your President's Page

A Full-Time Leader?

As I compose this month's message I am acutely aware that approximately two months from the time you read it you will be meeting to elect my successor. Like each president before me, I must face the fact that there is so much yet to be done and so little time in which to do it. During my term many projects have been begun but only a few have been finished.

The present concept of a president who practices medicine full-time and gives what time he can steal from his family, his reading, his CME courses and his social life to serving as your president is in need of serious re-examination by the Society. How much more effectively could your chief executive officer represent you to your legislators, to the HSA, to the media, the PSRO, the DPW, the DPH, the administrators of the hospitals and the many service organizations and agencies if he were a *full-time leader?* How much more could your Society accomplish in terms of its objectives, as determined by your Executive Committee, if this were the case?

Certainly there are a few doctors in Hampden District who would be willing and able to take on such responsibilities full-time right now. And within the next few years, as the bureaucratic red tape associated with private practice draws ever tighter, there will be many more doctors willing to retire from practice to work toward advancing the goals of the Society.

All it would take is the will of the membership and a nominal money commitment. Doctor Memery, Chairman of your Nominating Committee, Doctor Verrilli and I would appreciate receiving your comments on this.

Why continue to fight with one hand behind your back?

Bruce B. Stoler, M.D.

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THEME ARTICLE:

Some Aspects of Medical Practice Today and Possible Future Trends

by Carl W. Janovsky, M.D.

The present picture of physicians nationally shows about 380,000 total physicians, representing about 175 per 100,000 population. Only 80% of physicians render patient care and of these about three-quarters are office-based and the others are hospital-based. There are presently about 50,000 physicians in general practice although there has been some recent shift of interest by medical students toward general practice. In Hampden County we have a total of about 600 physicians with a breakdown similar to the national statistics.

There has been a definite shifting from solo practice to group practice with over 50% of physicians now engaged in group-type practice. Some of these groups are multi-specialty and others are single specialty. Hospital-based practice is also on the increase—most notably in primary care services, but also in secondary care services.

Hospital-based physicians are usually salaried or paid amounts by contract, but the usual mode of payment for office-based physicians is fee-for-services. However, prepaid capitation payment is the mode for HMO closed-panel groups. HMO (health maintenance organization) groups are being encouraged by the federal government as a possible way of cost containment. This expectation arises from the fact that HMO's contract with their subscribers to give comprehensive medical care for a fixed fee which is arrived at by an actuarial process. HMO's can also be open-panel physicians groups (IPA or individual practice associations). The Health Care Foundation of Western Mass. is presently involved, along with the other foundations of Mass., in discussion and preliminary studies with Blue Shield regarding the possibility of establishing a state-wide open-panel HMO. Several Health Care Foundation committees are very actively engaged in the preparatory planning with Blue Shield to put together an acceptable package. This would provide for visits to physicians offices (any physician of the patients choice)—as well as hospital coverage through Blue Cross.

Criticisms of health care delivery which have arisen include the following:

1. The rising cost of health care services.
2. Uneven distribution of doctors, with low relative density in rural areas and inner city areas.
3. Difficult access of health care.

Ernest A. Byron, Jr.

• • • • • •

SPRINGFIELD

The passing of the federal Health Care Planning and Resource Development Act of 1974 has given the Department of HEW considerable control over a national network of local Health Service Agencies (HSA's—which have supplanted the former B planning agencies) while providing the HSA's with planning clout regarding certification of need and avoidance of unnecessary duplication of medical services in the community. Regionalization of services has been promoted as a means of countering the uneven distribution of physicians. Also a proposal has been made to force newly graduated physicians to serve in so called under-served areas for a certain period of time. Apparently no hard effort is being made to push this proposal at the present time. The idea that health care services should be readily accessible to all individuals is being broadly supported as a civil right. Medicare and Medicaid have been efforts to increase general access to medical care, but have been criticized as not encompassing the entire needy population. Coverage for catastrophic illness is awaiting federal action. Also seen as passing in some form in the next few years, but perhaps of limited scope initially, is a national health insurance. This would give mandatory, universal insurance for health care services, but as might be surmised, would involve universal funding of huge yearly outlays. Some sort of contractual basis for delivering at least a portion of health care services might well be anticipated. Group practice and HMO development are certainly on the increase. Hospital-based primary care is on the increase. Health care delivery approaches are multiple and strive to accomplish universal accessibility with cost containment. Whether or not these goals are being reached should be under continuing evaluation and consideration.

Carl W. Janovsky, M.D.

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Summary of Comments on Regulations based on Chapter 283, Section 27 proposed by the Department of Public Welfare.

Submitted to the Department of Public Welfare by Walter F. Tauber, M.D.

The Department of Public Welfare proposes regulations to require "Second Surgical Opinion" by consultant(s) unknown to the treating surgeon. Eight categories of surgery are picked out for this requirement.

Hearings on proposed regulations by executive agencies are required under Chapter 30A, Sections 2 and 3. These have been requested by me and others.

The federal and state constitutions guarantee "equal protection" to all citizens. Title XIX of the Social Security Act provides for private care and dignity for Medicaid patients. The law and the proposed regulations deny such "equal protection" to Welfare clients and negate Title XIX.

If implemented, the regulations will undermine the doctor-patient relationship. The confidence the patient has in his/her physician will be seriously compromised under those circumstances.

The law and regulations use terminology in a loose way which makes words unintelligible. The words "indicated", "emergency", "urgent", "elective", "unnecessary" [surgery] have an entirely different meaning in quality medical care than the Department of Public Welfare wants to give them.

The Department of Public Welfare considers only life-saving surgical treatment and surgery to relieve intractable pain to be indicated. Recurrent illnesses and employability are totally ignored by the Department. No consideration is given to the evidence which strongly indicates that "self-image" sometimes plays a determining role in criminal recidivism or other anti-social behavior. The recognition accorded such indications by specialty societies, the courts and industrial compensation boards does not appear to impress the Department of Public Welfare.

Consultants are to be anonymous—as far as the treating physician is concerned. Such almost surreptitious procedure cannot benefit the patient.

Physicians will be subjected to added overhead and increased malpractice exposure. No provision is made to compensate for these expenses and risks. Expenditures of public funds for the "Second Opinion Program" will in all probability exceed savings due to surgery not done. The program duplicates existing quality control and cost-containment procedures. Current experience with review procedures indicates that very little unnecessary surgery is done in the Springfield area.

The proposed added red tape will discourage private care for Medicaid patients. With the resultant added demands on emergency room's and clinics, Medicaid costs will rise while continuity of care suffers.

Walter F. Tauber, M.D.

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FEATURED ARTICLE:

What Should We Render to Caesar?

H. Thomas Ballantine, Jr., M.D.

About 2000 years ago a man called Jesus was being subjected to unfriendly questioning by some of his fellow countrymen concerning oppressive taxation by the Romans.

"Tell us," they said, "Is it right to pay tribute to Caesar?" Jesus showed them a coin. "Tell me," he said, "whose face is on this coin?" His inquisitors replied that it was the face of Caesar; Jesus then said "Render therefore to Caesar the things that are Caesar's and to God the things that are God's."

Thus was stated a vital principle of human conduct: The obligations of a citizen to his conscience and his concept of morality must at times be different, and can even be in conflict, with the obligations which the State imposes or attempts to impose upon him.

On June 20, 1966, the American Medical Association, through its president James Z. Appel, issued a statement concerning a new law, commonly called "Medicare-Medicaid" which was to go into effect ten days later. A portion of this statement follows.

"Public Law 89-97 represents an undertaking of enormous magnitude with implications which cannot be foreseen in their entirety. It is impossible to perceive in advance all of the problems that Medicare will impose on physicians and their patients . . .

"Medicine long ago saw and tried to warn of the impact this program would have on patient care and the practice of medicine. Now this material [the regulations] makes us even more acutely aware of the costly administration, the intricate regulation, and the vastness of the bureaucracy involved in the implementation of Medicare.

"But we cannot surrender to resentment or resignation in the time of trial ahead. The position of the AMA since the enactment of Public Law 89-97 has been to try in every way open to us to make this law work as well as any such law can, to minimize its bad effects on the profession, to protect the right of physicians to make decisions and to prevent as far as we can disruption of service to patients.

"We cannot permit one shred of blame to attach to the medical profession for those flaws and shortcomings in this law which, I am sorry to say, must soon begin to manifest themselves. This effort, of paramount

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importance to all of us and the public we serve, will require the utmost of our strength and unity of purpose for many months to come."

In the ensuing decade the AMA's gloomy prophecy was more than fulfilled. Medical bureaucracy proliferated beyond belief. The costs of medical care escalated in a terrifying fashion; some states were brought to the brink of bankruptcy by the burden of Medicaid. And yet our state and federal governments still insistently and tirelessly attempt to intrude further into the individual patient-physician relationship and to expand bureaucracy to that end.

These infirmities of government, serious though they are, have not engendered a cry from the American taxpayers for repeal of the Medicare-Medicaid law. Moreover, we physicians, in order to survive, have been forced to become part of the Medicare-Medicaid system. We are saddled with this burden imposed by "Caesar".

Five years ago the Massachusetts Medical Society created the Commonwealth Institute of Medicine to assist physicians in this struggle to render to Caesar only that which is properly Caesar's. And almost immediately after its incorporation CIM was confronted with a problem of enormous magnitude.

The Massachusetts Department of Welfare had proposed to the leadership of Massachusetts Medicine a scheme to control medical care delivered to medicaid patients in acute hospitals. An in-house bureaucracy would have made fundamental decisions concerning hospital admissions, the duration of stay and in many instances the care provided. This proposal was intolerable to the Medical Society and it requested that Commonwealth Institute of Medicine produce a counterproposal which would fulfill the obligations of the physicians to be accountable to the state for the expenditure of medicaid funds but would preserve for patients and physicians the right to have medical decisions made by medical professionals.

A political roadblock was thrown in front of the state bureaucracy and after weeks of negotiation a contract was written between CIM and The Department of Welfare which stated in the preamble "The state and the Physicians of Massachusetts have developed a program intended to assure that persons enrolled in the medicaid program receive medical care of the highest quality in a manner which assures them treatment with dignity and respect . . ."

CHAMP (Commonwealth Hospitals Admissions Monitoring Program) began operations in 1973. To date over 350,000 hospital admissions have been monitored. To my knowledge in no instance has the state intruded directly into decisions made by a physician for the benefit of his patients. The state has, unfortunately, made sweeping (and often unjust) decisions concerning services that it will pay for but the individual patient-physician relationship has been preserved.

CHAMP directed its attentions primarily to length of stay in hospitals and in the three years of its operation only 13 CHAMP physician advisor

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Virginia H. Corcoran 733-8263

decisions have been appealed to the Massachusetts Foundations. In six instances the physicians' decisions to keep the patients in hospital were upheld. In seven instances the decision of the physician advisor was upheld but only 74 days of hospital stay were denied. These figures are a tribute to the physicians and the program; for an expenditure of less than 5 million dollars the state has, according to its own calculations, saved about 15 million dollars in hospital charges!

From its inception CHAMP has been described as a "preview of PSRO" and at this writing the PSROs are taking the monitoring of medicare-medicaid patients in acute hospitals; on or about June 30, 1977, this function will be totally assumed by the five PSROs in Massachusetts.

Since all practicing Massachusetts physicians will be subject to PSRO monitoring it is imperative that they become actively involved in local PSRO operations. They must render to "Caesar" public accountability for the manner in which the government funds which they use for the care of medicaid and medicare patients are expended; they must also resist the efforts of the bureaucrats to dictate to an individual physician how he shall care for an individual patient no matter who pays the bill! This latter problem will inevitably engender episodes of confrontation. Yet, physicians will emerge victorious if they firmly and fairly discharge their obligations to the state while defending vigorously the patient-physician relationship. They must keep ever in mind those words uttered almost two thousand years ago: "Render therefore to Caesar the things that are Caesar's and to God the things that are God's."

H. Thomas Ballantine, Jr., M.D.

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THEME ARTICLE:

Western Massachusetts P.S.R.O., Inc.

by Norman B. Pike, M.D.

The Western Massachusetts PSRO, Inc. was designated as an authorized Professional Standards Review Organization by the Secretary of the Department of Health, Education and Welfare in the spring of 1974. During its first year, the PSRO concentrated on internal organizational development, staff recruitment and committee formation. Granted Conditional status by DHEW in 1975, the PSRO then began working on the development of a formal review plan for Western Massachusetts short-term, acute-care hospitals and began implementing review procedures throughout these hospitals.

Professional review in hospitals is based on norms of medical practice, developed and/or adopted by the PSRO's seventeen medical and surgical specialty committees and applied in the review process while patients are still hospitalized (concurrent review). While current policies require that a hospital review 100% of all Medicare and Medicaid cases, the PSRO is considering modifying this requirement to a focused, in-depth review of a selected sample of these cases. In addition, retrospective evaluations of particular diagnoses, procedures or administrative problems are mandated in the form of Medical Care Evaluation Studies (MCEs). The PSRO, which will monitor review being performed in the hospitals and provide technical assistance where necessary, is also gathering data so that retrospective analysis can be used to document the high quality of care being provided by area physicians and to provide insights into areas of medical practice needing improvement.

In addition, the PSRO is looking ahead to several other areas of involvement. A major effort now being undertaken is the development of a review plan, similar to that which has been implemented for hospitals, for services provided to Medicare and Medicaid patients in long term care facilities. A committee of physicians, hospital administrators and nursing home representatives has recently been formed to evaluate existing review methods and to determine an appropriate approach for Western Massachusetts facilities. Also, the PSRO is making preparations to review ancillary services provided to Medicare and Medicaid patients in hospitals.

The PSRO program represents a well-intentioned effort by Congress and the Department of Health, Education and Welfare to assure that the medical care provided to beneficiaries and recipients of the Medicare, Medicaid and Maternal and Child Health programs is of high quality and that such care is provided in a manner which reflects the most appropriate and efficient utilization of health care resources. One "plus" of the PSRO program is that it has transferred authority for final determinations of medical necessity and appropriateness of care, for payment purposes, from the Medicare intermediaries and State Medicaid agencies to the PSROs—and through the PSROs, to practicing physicians.

Norman B. Pike, M.D.
President

THEME ARTICLE:

Health Care Foundation of Western Massachusetts, Inc.

by Robert N. LaMarche, M.D.

The Health Care Foundation of Western Massachusetts, Inc. was founded by practicing physicians, primarily in Hampden County, and endorsed by the four Western Massachusetts District Medical Societies in 1972. The primary purpose for its formation was to strengthen the role of the private practicing physician in decisions relating to the quality, cost and organization of medical care. Today, that purpose continues as the government (State and Federal) and other forces clearly have demonstrated their skepticism that physicians can act responsibly. Through medical organizations such as the Foundation, physicians can visibly demonstrate positive contributions in the medical care delivery system and be at the forefront in decision and policy making.

In 1974, the Health Care Foundation signed an agreement with Blue Shield of Massachusetts to implement a quality-oriented peer review system for services provided to Blue Sheild subscribers and Medicare (B) beneficiaries. In order that quality of care be the basis for all decision making, the Foundation's program specifically addresses the medical necessity and appropriateness of care being provided; it does not address itself to fees or charges. The heart of this program is diagnostic—specific medical guidelines developed and/or endorsed by over 150 Foundation member physicians serving on seventeen medical and surgical specialty committees. The successful implementation of this program (of approximately 468,000 claims submitted to Blue Shield from Western Massachusetts since the program's inception, about 37,500 or 8% have been reviewed under the program) has provided an educational experience for those participating physicians and at the same time has substantially influenced certain patterns of aberrant practice.

At present, the Foundation is working with the other Massachusetts Health Care Foundations and Blue Shield of Massachusetts to develop a prepaid health care program to be offered to all Massachusetts residents. The plan is expected to be co-sponsored with Blue Cross/Blue Shield and is being designed to combine the business-management characteristics of a Health Maintenance Organization in an environment of private medical practices. The Foundation program will differ from the traditional "closed-panel" HMO in significant ways. Among these are: Physicians will be reimbursed on a fee-for-service basis; patients will be free to choose their own physician from any Foundation member physician in Western Massachusetts; services will be reimbursed in the doctor's private office. Emphasis will be

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placed on ambulatory care, but services will always be provided in the most appropriate setting. Indeed, by encouraging the use of the most appropriate setting, offering a comprehensive range of services (including office visits), and providing for proper reimbursement to physicians, hospitals and other providers, the Foundation's program promises to be successful in providing a regional network of quality-oriented care.

Though the Foundation's primary interest today is the development of a comprehensive health care Plan, its efforts to assure high quality care are not limited to this area alone. The Foundation continues to be the focal point in discussions concerning the implementation of both State and private (mandatory and voluntary) second surgical opinion programs in Western Massachusetts. The State, Blue Shield and the commercial insurance industry see a substantial role for the Foundation, although the Foundation has not yet taken any action in this area. Also, the Foundation is involved in efforts with the commercial insurance industry, private industry, and special interest groups for purposes of expanding peer and utilization review activities to their programs.

The Health Care Foundation of Western Massachusetts is a member of the American Association of Foundations for Medical Care (AAFMC), the Massachusetts Association of Foundations for Medical Care (MAFMC), and is a highly visible leader in decisions relating to the organization, delivery, quality and cost of health care in Western Massachusetts.

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The Page of the Auxiliary to the HDMS

February 1977

Organized, pretty and a gourmet cook! Of course, I'm talking about Cynthia Bye your president elect. Cynthia has carried through several programs this fall for the benefit of the Auxiliary. As chairlady of membership, necrology and the medical welcome wagon she has succeeded in adding 25 new members to the Auxiliary. The welcome wagon committee has personally visited seventeen new families to the district.

On December 7th the annual Holiday Tea was held at Karin Silvas' with 75 members braving the storm to attend. Cynthia held a bake sale for all of us to supplement our holiday baking. Needless to say, it was a marvelous addition to the tea and very popular. $198.00 was raised for the Scholarship Fund. Thank you Karin, Lois, Louise, and Cynthia.

The December swine flue clinics were helped by more of our members. Thank you to Lynn Berger, Jean Gramse, Marguerite Leani, Elsie Smith, Dorothy Steinberg, Helaine Sweet, Doris Steele, Helen Siragusa, Barbara Verilli, Elaine Kobrosky, Pat Twible and Priscilla Dixon.

JAZZ, JAZZ, JAZZ. Betsy Stevens committee has planned a fun afternoon for all of us.... Invite your friends to a spectacular traditional New Orleans Jazz—pop-corn and roast beef sandwiches, March 27th at the Colosseum 4-7 p.m. Let's sell out the house again this year!

Carrol Jean Yorzyk

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The society hopes each member over the years will serve in some capacity. Please check an interested committee.

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Send form to: Mrs. Robert Bye (Cynthia) 170 Overbrook Road, Longmeadow, Mass. 01106

Res Ipsa Loquitur:

Observations in the Radiation Suite

Charles W. Barnes, Ph.D.

In 1930, Karl Menninger wrote a best-seller entitled, *The Human Mind.* In the opening paragraphs of that book he spoke of how a trout rising to the fly gets hooked and finds itself in a life-and-death struggle to escape. It was an anology. Sooner or later most of us get "hooked." How the fight proceeds depends on the hook, and, of course, on us. Then Dr. Menninger wrote a memorable line: "It is hard for a free fish to understand what is happening to a hooked one."

Life changed suddenly and radically for me. I was booked for my annual trip to a medical school symposium on family psychotherapy when emergency surgery for me was indicated. Radiation therapy was the follow-up procedure. To one trained in assessing human response, this seemed a ready-made opportunity for a study of the psych-social problems attendent upon radiation therapy. I resolved to explore the psychological impact of the experience on my own being. I have shared these thoughts and feelings with my own family and in the clinical situation where I practice. They are crystalized here. The challenge to write this down is perhaps to gain a cognitive mastery over highly charged emotional material. To get in touch with my own anxieties and to connect that to how medical specialists can work more effectively with the seriously and terminally ill seems appropriate. It is my own subjective perception about what was helpful and what was deterring, the view of a "hooked" one. The literature is full of the research findings of a more objective kind.

First, I was unprepared for the waves of anxiety that came with lying under what I came to call, "that machine." How vulnerable I felt, how aware of the size and parts of my body as I assumed the position of a sprawling nuisance. The anxiety was unlike that of pre-surgery. Something being put "into" my body felt more threatening than the feeling that something diseased was being removed. I wanted to run from the passivity demanded of me. Dr. Murray Bowen, a Georgetown Medical School psychiatrist, has a thesis that whenever anxiety increases in any emotional system, there is a tendency to move the system toward togetherness in order to relieve the anxiety. I tried to pull my own conflicting intrapsychic process together by focusing on objects and architectural designs of the room. Some FM music would have been helpful.

Secondly, I had a recurring sense of isolation. I noted that few came to the waiting room alone, bringing friends or family in order to dilute the intensity of that loneliness. Those moments in the waiting area became as dramatic as group therapy sessions; the need to communicate things of importance was apparent, each trying to bridge the isolation of the experience. The verbal language was nearly always symbolic, intent on making a family network. There was the "we-ness" (patients) and the "they-ness" (staff). My own attempts to connect with someone also came while I was prepared for treatment. I wanted to engage the technician, to know him or her personally. It was an invitation to be known as well. How often the technicians talked to each other rather than to the patient, almost unaware of the patient's need to be personal.

I found technicians seemingly unrehearsed in interactional styles

of communication, especially in encouraging identification, empathy, and verbalizing anxiety to another. My humor, an attempt to deal with my own anxiety, was considered inappropriate. I thought of Dr. Kuebler-Ross's finding that care-givers will often avoid talking with the seriously ill patient unless they have come to grips with their own fears and anxieties. Certainly staff has a need to preserve professional boundaries and not "burn out" in the face of constantly dying patients. However, I feel that such anxiety might be ameliorated by staff support programs. After a while, my failure to connect was felt as some sense of rejection, ready grist for reactive depression.

At one point in my life I had difficulty expressing anger as a secondary response. I did not want to alienate people, but to keep them loving and supportive. I would tend to suppress negative feelings; choosing between depression and the expression of anger was tough. I have learned to take responsibility for feelings and to ventilate in non-blaming ways. In my case, distressful behavior was often the result of *deprivation* of information. With no information about procedures we tend to fill in the gaps with our own projections and fantasies. I needed to be treated not as an impersonal object who was too fragile or too dumb to understand, but as a partner. I wanted to shout, and did, "You do nothing without my solicited cooperation . . . now involve me!"

I sensed the need of the staff to do things with dispatch. They were boxed in, like the absurd psychotherapist who was booked for ten hours back-to-back and had to handle all crises in fifty minute periods. Not even my termination was anticipated. One day they said, "No treatment today — you're through." I found irrational the way in which procedures were announced in a surprising way. I hoped for "tomorrow we will . . ." but it came as an imperative, "Now—today!" I found I could better integrate procedures when I was given advance notice, similar to the way I was prepared for surgery the night before it happened.

One such procedure was the unprepared shock of "losing" the technician who was responsible for my treatment. The feelings of attachment to the familiar, with attendent trust, were mishandled and I grew angry. My separation anxiety at being given a "new" face grew into anger. I felt that most patients, so needy of love and support from the medical system would say little about this in order not to alienate their care givers. Negative feelings would probably be suppressed. The "system" moved relentlessly on with its policy of "musical chairs," which perhaps increased patient depression and withdrawal.

In addition to all this, I had an urge to give something to the staff at the completion of my treatment. I suggested a bottle of champagne, and the "irrationality" of the suggestion prompted humor. I should be the one to celebrate the end, not the staff. It was a full-blown "liebesleben" fantasy, the feeling of people who sense they are or might be dying and who want to give the living a gift. The illusion of immortality is created by leaving something behind. It may seem inappropriate, but the staff needed to encourage and accept the symbol of such a need.

It seems proper here to suggest to such hospital units that a multidisciplinary oncology team might be developed that could take the initiative in forming either a "self-help" group (the "Make Today Count" model) or a professionally-led group based on traditional

(CONT. ON PAGE 27)

SERIES ARTICLE:

Views of a Hospital Administrator

by Mr. George B. Brooks
(With Apologies To Art Buchwald)

Hospital administrators are among the busiest people on earth. This is because hospitals are places that are packed with people, rife with reports and replete with meetings, all of which demand executive action from the administrator in order to provide care for the sick and injured. But there may be some who don't understand the full range of problems besetting the administrator. An experience I had the other day may demonstrate my point that administrators are extremely busy with vital matters.

I left my office to go down the corridor to x-ray and bumped into Ms. Brown from the Joint Underwriting Association.

"Oh, Mr. Brooks!" she cried. "You're just the man I was looking for; we must talk about your new premium for malpractice coverage."

"I'd love to Ms. Brown," I replied. "It's a subject the Finance Committee, the Controller, our Trustees and I spend many hours discussing. Shall we meet in my office later on?"

A few steps later I was greeted by Mrs. Nelson, the Utilization Review Supervisor from the P.S.R.O.

"Did you get our letter about the improvements we've suggested?" she asked.

"Yes, I did," I said. "I really appreciate those ideas to lower our length of stay. We thought we set a record last year but I can see you're going for a new low."

I made my way along the corridor and answered a page from the Controller.

"We've got a little logistical problem here, George," he informed me. "The RSC auditors are working here now in my office, the Medicare auditors are over in that empty room on the first floor and now our own auditors want to start tomorrow. Where can I find space?"

"First things first, Leo," I advised him. "Let's cancel those courses on 'Saving the Choking Victim' we had scheduled in the auditorium and that will provide the space they need."

When I reached x-ray I found the State Radiation Inspector was fin-

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ishing up and wanted to talk with me.

"No big problem," he said, "but the foot switch in room 3 ought to be moved about 6 inches to comply with the code. The room won't be down more than two days if they don't run into trouble."

"Gee, that is good news," I said. "I'll tell Genia to cancel the BE patients she had scheduled for that room."

I retraced my steps down the corridor and noticed a little crowd of people coming out of the elevator. They were being led by our Chief Engineer, Nick.

He hailed me. "George, I'd like you to meet these gentlemen: Mr. Harris from OSHA, Mr. Collier from the Casualty Insurance Underwriting Corp. and Mr. Gallo from the Department of Public Safety. They all want to inspect our buildings today and I don't see how I can escort them all."

"No problem, Nick," I said. "Just hold up on that boiler repair job and then you can free two men to assist these gentlemen. There's a 50-50 chance we won't need any extra heat."

A moment or two later I was paged by my secretary.

"There's a phone call from WMHPC," she said. "They want to know if you've completed the questionnaire they sent about the HSA's HSP."

"Tell them we're working on it," I replied. "But I'm trying to prepare for a two-day visit of the JCAH and also memorize DPH's newest DoN regulations." "Besides," I added, "I'm on their EMS sub-committee as a representative of the WMHC and I think all of us together with MHA and TCC can work out something."

Pressing on, down the corridor, I was pulled into the Record Room by the Librarian. She was agitated because representatives from both Blue Cross and Aetna wanted her to pull charts for their review.

"We have to be cooperative, Mary," I advised her. "Just hold up on transcribing the pre-op physicals and I'm sure you can accommodate our friends."

When I finally entered my office I found our Director of Nurses and Director of Social Services waiting for me.

"Can you give us a minute?" she pleaded. "We have to come to a decision about a patient care problem we're having upstairs."

"Good God, woman!" I retorted. "I'm much too busy for that sort of thing. Can't you work it out yourselves?"

This experience will give a good illustration of how busy we hospital administrators are. Occasionally we face distractions. We must deal firmly with them to avoid being diverted from our goal of providing good patient care.

— George B. Brooks, Administrator
Noble Hospital, Westfield, Mass.

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PRESIDENTIAL COMMENTS:

There has been quite a brouhaha among the membership over the fact that AMA will again this year sponsor a National Health Insurance Bill. The idealists say the whole idea is repulsive. The realists say that NHI is an idea whose time has come and that AMA must give the Congress an alternative to the more radical NHI bills introduced by others.

What are the principal features of AMA's NHI Bill?

1) Builds on the present system.

2) Provides federal assistance on *basis of need.* The most help goes to those who need it most.

3) Allows everyone to *choose* his own physician, dentist, health insurance plan and type of practice arrangement.

4) Provides more *comprehensive benefits* than any other bill and includes coverage against costs of mental illness.

5) Protects against costs of *catastrophic illness* without any ceiling on benefits.

6) Provides realistic *preventive care* benefits including well-baby care, physical exams, immunization, out-patient psychiatric care and x-ray and lab work.

7) Provides continuation of coverage for the *unemployed.*

8) Provides supplemental coverage for non-employed *medicare enrollees,* bringing their benefits up to NHI level.

9) Cost control by: limiting federal help to those in need, coinsurance (except for the poor), competition among carriers and providers, many services on ambulatory basis to avoid hospitalization.

10) Least expensive of all NHI bills in new federal spending—approx. $2.5 billion additional cost, excluding coverage of unemployed.

Bruce B. Stoler, M.D.

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FOOD FOR MEDICAL THOUGHT:

Second Area Doctor Heads South Of the Border

By Hank Reinink — *The Napanee Beaver*

Dr. Dave Miller, of the Deseronto Lions Medical Clinic is leaving Canada on Jan. 6 to practice medicine in the United States. He is one of a number of Ontario physicians, who are unhappy with the way things are going in their native land and who have elected to start over again across the border.

He is going to the rural tobacco farming area of Kentucky where an office will be ready for him on Jan. 17 in a community of 4,600.

In this area, Dr. Miller is not the first to leave. Dr. Ed. Dow, who practiced at the Richmond Medical Clinic, left for Texas last June, and at least one other local doctor is considering to take the step.

"I like where I live, I like my job and I like the friends we have here. So why the hell should I leave?" Dr. Miller said to The Beaver last week. As he laboriously cleaned his pipe, he proceeded to answer his own question.

"I am familiar with the British health care system, and I can see that we are going to have the same kind of socialized medicine in Canada. The provincial government has been moving along that road for several years now, and I would say up to 80 percent, we have evolved into a socialized medicine system."

"Socialized medicine appears to be free, but in fact it is very expensive," Dr. Miller continued. "If we were an infinitely rich country we could afford it. People tend to abuse a service that is free, and they go to the doctor with ailments of low urgency for which they might not seek treatment if they had to pay for the doctor's services themselves."

Sees Problems

"I expect that in time each physician in Canada will be assigned a group of patients, and the Government will pay the doctor a certain fixed fee, no matter who the people in the group are. The physician then finds that no matter how hard he works, it won't change his yearly income, and consequently the quality of his care would slip. Then, in order to control the quality of the doctor's work, a council will be established to take the doctor to task for failing to make a house call at three o'clock in the morning to treat somebody's hangnail."

In England the physicians are told how much they can prescribe in drugs during any one month, and if they prescribe more than the allotted amount, they have to pay for that themselves," Dr. Miller said.

"I am willing to take less money per hour than an electrician or a train driver, I am willing to take the abuse from newspapers and government, but I am not willing to have the government tell me how, when and where to practice medicine."

"If things stay the way they are now I would be willing to stay," he said. "But I know in my own mind that we are continuing to go down the road in the direction of socialized medicine. Now I can either wait for the axe to fall and move then, or I can wait for the axe to fall and then change my profession, (I am pretty good at cabinet making, plumbing and wiring) or I can look now for an alternative."

"And the only non-socialized medical system in the world is in the

United States," Dr. Miller continued. "Socialized medicine will come there too in time, but I will have five to 15 years to practice free enterprise medicine there. When it comes there I will have no alternative but to change my profession."

The Ontario Medical Association (OMA) has proven to be an ineffective vehicle through which physicians fight for their betterment, Dr. Miller said. The executive of the organization is made up of a group of older medical specialists, who are entrenched in the top of the association and who don't have "that burning need" to fight governments for freedom or the increases in fees most doctors feel should be coming to them.

Blames Association

"The OMA executive mismanaged Government-OMA relations," Dr. Miller said. "In fair weather the president can be a monkey, but when things start to go bad you need a very astute individual. The economic committee of OMA figured last year that the physicians' purchasing power had lagged 42 percent behind that of the rest of the working population since 1971. But the executive settled for a 7.5 percent increase in fees. This year the committee proved we had fallen 55 percent behind since 1971, and the executive settled for 6.5 percent."

"Everything the Government wants goes with the executive of the OMA," Dr. Miller charged. "OMA is a very weak organization and very unable to change the course of things."

Dr. Miller said news reports claiming that doctors make huge incomes are distorted. The costs of running a practice have gone up much more than the fees and so have the incomes of practically all other people in the work force. He estimated the average net income of local general practicioners at around $40,000 per year before taxes.

"Expenditures in the health sector in Canada is a tremendous amount," Dr. Miller said. "This has to be curtailed, and physicians in general will agree with that. But what the physicians take out is only 14 percent of the total. And that is the doctors' gross income, which includes the cost of drugs administered, nurses and secretaries they hire and upkeep of the building."

Wants Cost Curtailed

"Hospitals have the biggest appetite, they eat money like the cookie-monster eats cookies," the father of three small boys continued. "A hospital bed costs $90 to $200 a day in Ontario. To curtail the cost the government is attacking the small hospitals, because they are the weakest. The Government will claim there is duplication of service if an operation can be had in another

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larger hospital not too far away, and so they work to phase out the smaller hospital. They strangle them with budgetary restrictions, so the hospitals can't improve their medical facilities."

"Once that strangling has started it is a malignant process. It inevitably causes internal destruction. I expect the Napanee hospital will be turned into a nursing home if nothing is done. Conceivably, that will happen in two year's time."

"It must have been a tremendous effort to get the Lennox and Addington County General Hospital started," Dr. Miller said. "It is terrible to see it fizzle away. But I could not fulfill my medical desires without a hospital and that is the second reason why I am leaving."

The Napanee Beaver
Wed., Dec. 15, 1976
Submitted by John J. Zadworny, M.D.

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Those operas designated "soap"

Are ones with which I cannot cope.

4th day.
If time is ever of the essence

It damn well is in convalescence.

5th day.
I'd gladly strangle all the bards

Who pen those cheery get-well cards.

6th day.
I'll challenge anyone to eat

This boiled potato and the meat.

7th day.
One thing about this room I will

Be glad. Insurance pays the bill.

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A Doctor's Prayer

By Dr. John J. Alifano, Sr.

Almighty God, Eternal King of Kings,
Our Father now and since the world did start,
I pray Thee, O creator of all things,
Keep me alert, adept in science and art.

Give me, dear Lord, the constancy to bear
All burdens, tasks of this pursuit of mine;
Give me Thy hand when I am in despair,
Assuage my grief when I am ill or pine.

Obliterate the evil from my mind—
All selfish, greedy thoughts and my false pride.
Replace them with new meanings always kind,
With good perception and with wisdom wide.

Increase my knowledge, guide it towards the aim
Arranged by Thee; but if I make mistakes—
As make I must—please, mitigate my blame:
A human being I am with all heartaches!

Give me determination, light and strength
With courage high; let me not vacillate
Along my paths, in all their width and length.
High minds to never yield, they elevate.

Restrain my wrath and my complete disgust
When I am down and spurred on to react
Against all wicked creatures lacking trust,
Whose guilt, bad faith are manifest in fact.

Oh, let me smile with Thee, let me rejoice
When Magdalenes I saw, now have in store
Redeemed ideals and walk with different voice,
Without the sin which once they had before.

The tainted men, transgressors, foes, outcasts
I cannot shun and hate (part of mankind);
They will belong to us until life lasts;
If I am rough with them, keep them in mind.

Oh, give me vigor, keep me sound and clean,
Untouched by any spurious appetites;
Keep sacred all the good that I have seen,
Uphold my oath and vows and all my rights.

Oh, spare me jealous acts and envy too
Of my colleagues whose skill is high, supreme;
Let me respect them all and keep in view
My need for their approval and esteem.

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Oh, let my conscience be serene
and clear
And let me have power, at any rate,
To soothe all sorrows, pains, free
from death's fear,
When all is failing and appears too
late.

Give me the wisdom to detect the
flaw
In my desires, in words, in what I
say.
Give me the light to make me see
Thy law
And lead me to Thy home, yes, day
by day.

Let me not have an ostentatious
fame—
For all is vain without achieving
deeds,
Without the glorifying of Thy name,
Without Thy aid for all our mortal
needs.

Keep me, my God, in constant
discipline
Like those good soldiers, faithful,
proud and strong.
Give me full faith in my complete
routine.
And, while I work, give to my heart a
song.

Direct my eyes to see distress and
pain
In creatures ill in body and in
soul.
Let not my flesh succumb to
lust's domain;
Let not the golden rule desert my
goal.

O God, hear me, please, strengthen
my belief,
Remain with me always through
day and night.
I but advise, but Thou dost give
relief;
Thou movest all with universal
might.

From Dr. Alifano's book
Fruits and Fertile Fields.

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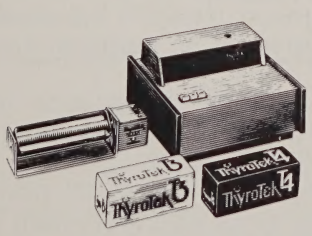

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(CONT. FROM PAGE 19)

group psychotherapy models where such issues might surface.

Being seriously ill in our culture is now a highly institutionalized experience. Life and death no longer *seem* to the patient to be in the hands of the physicians, but in the institution. Death is, on the other hand, a very *individualized* experience full of personal necessities. When the treatment lacks the personal dimension, I suspect we die sooner, our death elaborated by our depression. Perennial vigilance about the personal must be just that—perennial.

Senior Psychologist,
Mental Health Associates
Springfield, Mass.

Editorial Comment
"Roots" and the Concepts of Freedom — Personal and Dependent

The TV serialization of Alex Haley's book *Roots* will stimulate another culture shock and turn many to analyzing their own feelings towards freedom, either personal or dependent. Regardless of ancestry, geographic origin, recent emigrant or first family, Mr. Haley's book and its dramatization for television has provided all of us an excellent mirror in which to view and review our ideas and feelings towards individual or personal freedom and towards its opposite measure mutual or dependent freedom. Social gatherings are bound to be enlivened when the question of "What do you think of *Roots*?" is brought up. The faults and glossing over, not withstanding, *Roots* does bring out gut reactions and heightened awareness of ones own bias and unsuredness of what should be done (if anything) to correct the persistant calamity engendered by American slavery.

As the genetic and social product of a stern first family sea captain and a German emigré, whose early development in New York City was followed by adolescent indoctrination in Baltimore's segregation, which in turn was followed by the Quakerism of Philadelphia and all molded in the seclusion of a WASP milieu, my emotional response to *Roots* and its social and cultural significance is at first reading very different from yours and that of each other reader. The degree and quality of guilt, rejection, sympathy or understanding that we each feel will reflect our age, cultural background and degree of empathy for the whole huamn race and our American fellow brothers and sisters. What we are today reflects where we were and how we hold concepts such as personal or dependent freedom.

The explanations of situations viewed on the TV screen to my 13 year old daughter would have made interesting listening for psychologists and humanists. The good ghetto of Longmeadow prevents appreciation of the agony of the slave ship. Unless confinement or loss of personal freedom has taught directly, the American white can not experience the suppression, cannot equate the total helplessness of the American black up to 1864. The concept of people as chattel, as breeding animals for personal wealth, as things for personal pleasure—to keep guests or the massa warm is hard to convey or project to the unexperienced, except if the slaves are likened to our family pets. Pets or slaves who know no personal freedom only unilateral dependency.

The XIIIth, XIVth, and XVth amendments to the Federal Constitution did not change the master to slave mentality of the white, who soon found extra-constitutional ways to recover his supremacy and resubjugate the black citizen. Personal freedom did not stem from the North nor from the reconstruction programs; the black was now faced with a different white mentality equally against him or her. It took 100 years and Watts and the march to Selma. It took the recognition of a"nigga preacher"by a foreign Nobel Prize Committee to shake the caucasian soul and stir its mind. The American Dream expanded with "I have a dream"; perhaps year 2064 will witness a total universality of that dream for all mankind. White conscience now reveals that the slavery or subjugation of any person has always

resulted in the slavedom of the master as well. The removal of personal freedom, even through the guise of dependent freedom always destroys human liberty and fosters totalitarianism.

When did we first see black faces in the TV commercial? That surprise to me has worn away; now I am able to follow the commercial and not the black actors. Thank goodness that my daughter accepts these changes without concern and as expected. Perhaps my principles of personal freedom, as related to race, have been absorbed by my children and their standards of intra-racial conduct, of personal and dependent freedom, will continue to help Martin Luther King's dream to become reality and not another nightmare. Then this country, which derives its power from the consent of the governed, will grow onward and upward and equal will mean equal.

The single person on an uninhabited, tropical island without higher animal life, alone can experience 100% personal freedom and 0% dependent freedom. As manipulatable animals or persons are added the percentage of personal freedom drops and dependent freedom increases. The presence of a member of the opposite sex should create a 50-50 ratio. As more people are added, the interaction of an individual to the resulting society further changes the ratio. Yet we all would agree that the benefits of these interactions far outweigh the loss of personal freedom. We all have opted to cope with a modified personal freedom or we would have taken our own lives or retreated to hermetic island life. Perhaps Eve and Adam were the only humans to experience 100% personal freedom—their dependent freedom went to the Diety, at least until the apple incident. Their freedom plummeted as their responsibilities increased. As man's numbers grew through begetting, he organized into societies of varying expressions of and for personal and societal freedom. As power concentrated in fewer hands, only those hands knew or thought they had more personal freedom; but this was an abnormal freedom not truly personal but primarily dependent. The ultimate personal freedom becoming the master/slave relationship and the ultimate dependent freedom the slave/master relationship,with both never free, or free from each other. Only our founding fathers and our constitution provide the alternate and superior means to human relations.

I am sure *Roots* will cause much ink to be spread; it should produce another national culture shock of the first magnitude and may well pose a sincere problem for our new president.

The editor-in-chief

The fact is, that civilization requires slaves. The Greeks were quite right there. Unless there are slaves to do the ugly, horrible, uninteresting work, culture and contemplation become almost impossible. Human slavery is wrong, insecure and demoralizing. On mechanical slavery, on the slavery of the machine, the future of the world depends.

The Soul of Man Under Socialism
Oscar F.O.'F.W. Wilde 1895

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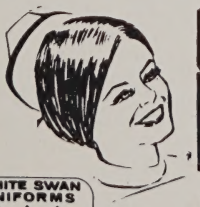

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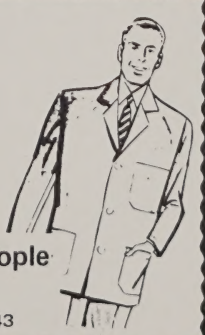

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